Bupa Care Homes (CFHCare) Limited

St Nicholas Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

St Nicholas Nursing Home is owned and operated by BUPA, a large national organisation. The home provides nursing and personal care for up to 176 people in six separate units. Three units provide general nursing care; one provides nursing care for people living with dementia. One unit provides personal care to people with dementia and one provides nursing care to people who have a learning disability. The home is set within a residential area and is close to all amenities and public transport.

There were 87 people accommodated at the time of the inspection.

This was an unannounced inspection which took place over three days. The inspection team consisted of two adult social care inspectors, two pharmacy inspectors, a nurse specialist advisor in wound care and an 'expert by experience'. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last inspected the home in February 2016 and found serious breaches of regulations. The home was rated as 'inadequate' overall. We placed the service in special measures. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

We had already taken enforcement action from our previous inspection in July 2015. We had issued a notice to stop any further admissions to the home. The statutory notice we issued remained in place at this inspection.

At our last inspection in February 2016 we had found the home in breach of regulations relating to safe administration of medicines. This was because people were not always protected by the medication administration systems in place. At this inspection we found people were still not protected against the risks associated with medicines because the provider's arrangements to manage medicines were not consistently followed.

We found most people were assessed for any risks regarding their health care needs. This was not however

consistent across all units and we found that some clinical risks such as, pain assessment and management, assessing risks around people with diabetes, people assessed as risk of falls, and risk of inadequate nutrition were not being consistently monitored. The risk of not updating changes to peoples care plans is that staff might be unaware of their changed care needs. There is therefore an increased risk that specific areas of care might not be effectively monitored and reviewed exposing people to unnecessary risk.

We found staff needed to be more aware of the first aid procedures and equipment used in case of an accident or emergency.

We found that the home was not fully operating in accordance with the principles of the Mental Capacity Act 2005 (MCA). Although there were examples indicating good practice we found some hesitancy and misunderstanding in particular around the use of the 'two stage mental capacity assessment' and when this should be used as part of making 'best interest' decisions for people.

On the previous inspection we found the systems in place to monitor on-going standards in the home had not been effective. On this inspection we found the service had many well developed systems in place to monitor the quality of care in the home. However, there were still areas of clinical care management, such as medication safety, that remained in need of improvement and had not been monitored effectively by existing audits and systems in the home.

The concerns we identified are being followed up and we will report on any action when it is completed.

We saw references in care files to individual ways that people communicated and made their needs known. We also saw examples were people had been included in the care planning so they could play an active role in their care although this was not consistent across all units.

We made a recommendation in the report.

We saw that an underlying component to some of the continued failings was the accessibility and user friendliness of the care records and documentation in use. We found care records extremely bulky and difficult to negotiate and to find information.

At the last inspection we identified shortfalls in care for people who had specific clinical care needs around wound care. We found that assessments and care planning for some of these people had not been updated and implemented to ensure care was safe and reflected people's changing needs. We found this area of care had improved and wound care and people whose skin integrity was at risk were being monitored well.

Previously we had found that there was a lack of support for nursing staff to fully develop their skills and knowledge to effectively manage some aspects of clinical care. This had also improved with clinical staff having undergone training and supportive supervision to assist them in their clinical work.

We observed there was enough staff to carry out care in a timely manner. We saw staff were attentive to the needs of people and no one appeared to be in distress through lack of attention.

Staff files showed appropriate recruitment checks had been made so that staff employed were 'fit' to work with vulnerable people.

People we spoke with and their relatives told us they felt safe in the home. People knew who to speak with if they felt concerned about anything. We made observations on all units including those specialising in

people with dementia and learning disability. We saw that people who could not express their thoughts and feelings vocally were settled and supported. Staff were observed to be attentive to people's care needs as they arose. Nobody we spoke with or observed expressed any issues regarding their safety.

There have been a number of safeguarding investigations at St Nicholas Nursing Home since our last inspection. The home had assisted the local authority safeguarding team and agreed protocols had been followed in terms of investigating. This helped ensure any lessons could be learnt.

We found that the home was clean and hygienic.

We observed meal times and saw that meals were served appropriately and the portion size was also appropriate. We saw that people who needed support to eat had sufficient staff time allocated and that staff took time to talk to and socialise with people.

People we spoke with and their relatives said that they (or their relatives) were being treated with respect, dignity and kindness.

A complaints procedure was in place and most people, including relatives, we spoke with were aware of this procedure. We spoke with the registered manager who showed us how complaints were recorded and responded to.

We saw that people were provided with t range of social activities and these continued to be developed.

The rating for the key question 'Is the service safe?' is 'inadequate' for the fourth consecutive inspection. This means that the service remains in 'Special measures' by CQC.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we may take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

We found that people were not protected against the risks associated with medicines because the provider's arrangements to manage medicines were not consistently followed.

The assessment of care did not always ensure the welfare and safety of people. Changing care needs had not been assessed or reflected in the risk assessments and subsequent care planning in some instances.

We found staff needed to be more aware of the first aid procedures and equipment used in case of an accident or emergency.
There was enough staff on duty at all times to help ensure people were cared for in a consistently safe manner. Recruitment processes were thorough and helped ensure staff were fit to work with vulnerable people.

The home was clean and we found systems in place to manage how infection control was maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not wholly understand understood and were not always following the principles of the Mental Capacity Act (2005).

Staff were supported through induction, appraisal and the home's training programme.

There was support for people's health care needs and when needed people were referred for appropriate support to health care professionals.

We saw people's dietary needs were managed with reference to individual preferences and choice.

Is the service caring?

Good

The service was caring.

People living at the home were relaxed and settled. Relatives told us they were generally happy with the care and the support in the home.

We observed positive interactions between people living at the home and staff. Staff were observed to treat people with privacy and dignity although we highlighted some examples where improvements could be made.

People we spoke with and relatives told us the manager and staff communicated with them about changes to care and involved them in any plans and decisions.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The existing good practice regarding the individualisation of care plans and records needs to be extended to all people's care.

A process for managing complaints was in place and people we spoke with and relatives were confident they could approach staff and make a complaint if they needed.

We saw that people were provided with a range of social activities and these continued to be developed.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were areas of clinical care management that still needed to be improved and these had not been identified by existing audits and systems in the home.
We found care records extremely bulky and difficult to negotiate.

There was a registered manager in post to provide a lead in the home who was supported by other key personnel.

We found the registered manager and staff to be open and caring and they spoke about people as individuals.

There was positive and caring culture in the home.

There were systems in place to get feedback from people so that the service could be developed with respect to their needs and wishes and these had been improved since our last inspection.

St Nicholas Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection which took place over three days on 30 August to 1 September 2016. The inspection team consisted of two adult social care inspectors, a pharmacy inspector, a specialist nurse advisor in wound care and an 'expert by experience'. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the visit we visited all five of the units that currently make up St Nicholas Nursing Home [one unit was closed]. These included two units supporting people living with dementia. Some of the people living at in these houses had difficultly expressing themselves verbally. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We were able to speak with 22 of the people who lived at the home. We spoke with 10 visiting family members. As part of the inspection we also spoke with two health care professionals who were able to give some feedback about the service.

We spoke with 30 plus staff members including nursing, care/support staff and the registered manager. We also spoke with another senior manager in the organisation.

We looked at the care records for 21 of the people living at the home, three staff recruitment files, medication records and other records relevant to the quality monitoring of the service. These included safety audits and quality audits, including feedback from people living at the home and relatives/visitors. We undertook general observations and looked round the home, including some people's bedrooms, bathrooms and living areas.

Inadequate

Is the service safe?

Our findings

At our last inspection in February 2016 we found the home in breach of regulations relating to the safe administration of medicines. This had been an on-going breach of regulations since January 2014. This was because people were not protected by the home's medication administration systems which were in place. We told the provider to take action.

The provider's action plan told us that systems had been reviewed and improved.

At this inspection we found there had been some improvements on one of the units we visited but overall the management of medicines remained unsafe; particularly on two of the units, which put people's health and wellbeing at significant risk. We did not inspect the management of medicines for the learning disability unit [Brocklebank] or the residential dementia unit [Gladstone] as on previous inspections they were found to manage medicines safely.

We looked at a sample of medication records and medicines on Langton, Canada and Huskinson units, as well as other records and documents relating to the management of medicines.

Although there were improvements in stock levels and fewer people ran out of medicines, we saw that medication was still not obtained safely. For example, one person ran out of their medication for two days. This medication must not be stopped suddenly because of unpleasant effects which can be avoided by gradual dose reduction. The person was therefore at risk of experiencing unpleasant avoidable side effects.

Another person who was living at the home ran out of Gluten free bread for five days. Staff told us this happened because there was a fire at the bread factory. The staff had not made any attempt to source the bread elsewhere else and the person had been given normal bread for the five days. This had the potential to cause significant discomfort. The nurse we spoke with raised the issue with the kitchen but the response to find an alternative supply was poor.

Missing doses of medicines places people's health at risk of harm.

People were still not given their medicines safely. The provider action plan told us a system had been implemented to record the start and completion time of each medication round. This was so nurses could administer medicines which had a minimum time interval between doses such as, paracetamol, safely, or give medicines that had to be given at a specific time. However, we saw that the times of the medicines rounds were not always recorded, so it was not possible to tell from the records if medicines had been given safely.

On Langton unit the records showed unsafe time intervals; evidence that people being given evening and bedtime doses at sub four hour intervals on a regular basis. This has the potential to cause liver damage in the frail elderly as it was not a one off event. In one example a person's tea time and bedtime doses were given at less than three hour intervals on three out of a seven day period. In another example, paracetamol

was given over 11 days of which eight days were administered at unsafe levels. On three days not all dose times were recorded.

Huskinson unit did not record actual time of administration of these medicines. Only the 'medicine round' times were recorded; this meant there was no way of knowing if any doses were given safely.

In addition a person on medication to be given at specific times, for a neurological medical condition, was not getting the medicine at the relevant time on the day of our inspection. This placed the person at risk of unpleasant symptoms such as difficulty with movement and at risk of stress as they had not received their medicine on time.

We saw people were prescribed thickening agents to thicken their fluids to prevent them from choking, aspiration pneumonia and chest infections. As at the last inspection the failure to manage thickening agents safely placed people at risk of harm.

We found that information on the use of thickening agents on all units inspected was either out of date or incorrect. On Canada unit the nurses had written on the thickening agent tin the wrong number of scoops to be used, as this was not in accordance with the number of scoops assessed as needed and prescribed. The hostess [staff assisting for meal times] confirmed they followed what had been written on the tin and had given the wrong thickness for days. The thickness was to thin which placed the person at significant risk of choking.

On Langton unit the nurses also wrote on the tins. The information here was correct however the hostess shared a tin of thickener between two people and although they were prescribed the same thickening agent they needed their fluids thickened differently. The tin in the kitchen had the direction for syrup thickness however the other person needed thicker custard thickness. There was a risk that people were being given liquids of the wrong consistency [too thin] placing them at significant risk of harm.

The records about thickening agents for drinks were not made at the time they were given by care staff / hostesses. They were sometimes written in the notes at 3pm when note writing took place. We were told this was a BUPA policy but when we reviewed three records we found little evidence that care staff had used thickening agents. The hostess made drinks but did not write in the notes. This meant the person administering the drinks was not recording they had administered the prescribed product.

The thickening agents used on Langton were not stored safely as they were accessible to people. We also observed the unsafe storage of items in people's rooms such as steridient tablets in bedrooms on wash basin sinks. Both these products have been known to cause severe outcomes for people when accidentally ingested. Likewise we saw creams left on bedside units which presented with a similar risk. We saw there were a high proportion of people on Langton unit who appeared confused which increased the risk. Staff on the unit had not considered the risks, as part of people's plan of care.

As at the previous inspections we looked at records for people who were prescribed medicines to be taken "PRN" [when required] including medicines prescribed for when people became very poorly. The action plan sent to us to tell us how medicines would be given safely advised that these protocols would all be in place.

We found there had been improvements. For example, on Canada unit the PRN protocols we saw were detailed and person cantered in that they gave a detailed description of when the medicines were to be used so staff were appropriately guided. However, there was still no information to guide staff to select a dose when there was a choice. The PRN plans on Langton unit were generic and usually said to 'observe

facial expressions and body language'; this was for analgesia, laxatives and thickening agents. There were no descriptors of what staff should look for each individual to support more individualised care.

One concern was a failure to monitor the effectiveness of PRN doses in line with the service's own assessments. We saw that for three people on Huskinson unit they had a care plan which stated a pain scale should be used to assess analgesia PRN. This was because these people were living with dementia and had limited ability to express pain verbally. The pain scales were not being used on a daily basis. Pain was only assessed monthly. We discussed the risks of not assessing the person's pain in real time, a number of times a day, to see if further pain relief was needed. Failure here meant that people may not have their pain assessed appropriately; some may be in pain but not assessed until four weeks later.

There was a system of recording the effectiveness of medication on the back of the medication administration records [MARS]. We saw this for the use of a medicine prescribed PRN for the relief of a specific medical condition. Sometimes the evaluation was nine hours after the dose was given or, conversely, at the same time the dose was given. This time frame was unreasonable and evidenced a poor understanding of the assessment process in this particular instance.

We found a person had been placed at risk following the PRN use of laxatives. On Canada unit one person had a PRN plan which said they would ask for the prescribed medication and to monitor the person for the effectiveness and if, after two days there had been no effect, staff were to refer for medical review. We saw the person was given laxative medicine on 19, 22 and 25 August with no result until 28 August. There had been no medical referral as indicated in the care plan. We were concerned that the daily notes recorded the person suffering significant effects from this including bleeding and rectal prolapse and to 'continue to observe for deterioration'. There were no subsequent observations recorded for the three days following. Risk factors for rectal prolapse include chronic constipation and straining to pass bowel motions.

We found there was a failure to implement dose changes when people had been reviewed. For example, on Langton unit one person had lost considerable weight over a three month period and had been referred back to the dietician. The dietician sent a fax on 26 August at 17:45 to increase the nutritional supplement. There were notes made in the person's daily notes to this effect by unit staff. The person's dietary supplement had not been increased however for five days.

Another person had an increase of dose of their Parkinson's PRN medication. The nurses failed to understand the dose change faxed through which meant the person would have been given an incorrect dosage.

This remains a breach of Regulation 12 (1) (2) (f) and (g) of the HSCA 2008 (Regulated Activities) Regulations 2014.

There were improvements in other areas of clinical practice but found some examples of clinical assessment and care that did not fully support people and minimise risk.

For example, one person we saw was very constricted with both arms and legs crossed and tight to their body. The fingers of their hand were turned into the palm. Movement was extremely limited and there was a strong risk that dressing and bathing would cause discomfort and possibly pain. We could not find any evidence this had been assessed and no consideration of pain relief was made within their care plan. We spoke with staff who confirmed that there was no mention of this care need in the person's care records. As such the service had not assessed the risks associated with the person's medical condition to ensure the person was provided with care and treatment that was safe.

Another person had sustained a fall and was observed to have bruising around their head. Following the fall the person had been sent to hospital and returned to the service within 24 hours. There was no mention of the bruising in the person's care records and there was no evidence that the person had been monitored for any pain. They had not been assessed for any pain relief. Additionally the person had transferred between units and there was a lack of information in the care plan as to how the person's falls were to be managed. The unit manager agreed to implement a care plan for falls immediately.

The lack of staff identifying clinical risk was further evidenced by a safeguarding investigation prior to our inspection. This was around a serious injury sustained by a person who was receiving care at the home and investigated by the police. One concern from the incident was that the person's injury had not been referred for medical review following identification of bruising for two days until reported by a visiting relative.

As part of our inspection we reviewed arrangements for the provision of first aid if required. We saw that units had a first aid box but the content of these varied [seen on Gladstone and Brocklebank]. Staff on each unit were not sure what the contents should be and there was no standard check list. There was no evidence first aid boxes were routinely checked.

We asked about the use of equipment such as the use of airways. An airway [leurdal mask] was produced on one unit but not on the other. Also the use of mechanical suction if required. Staff on both units were unsure as the whereabouts of any such equipment. There was no evidence that routine checks were made on equipment or whether first aid procedure was routinely audited. The registered manager said they would address this. There was good reference in the procedures manual on the units regarding resuscitation. The registered manager told us this would be highlighted for revision at staff meetings. Following the inspection we received reassurance that first aid practice had been reviewed.

These findings are a breach of Regulation 12 (1) (2) (a) and (b) of the HSCA 2008 (Regulated Activities) Regulations 2014.

At the last inspection we identified a number of concerns regarding the management of pressure ulcers and associated wounds, for example, skin tears and surgical wounds. Pressure ulcers are caused by 'sustained pressure being placed on a particular part of the body'. We found this area of care management had improved. All of the wound care plans reviewed (seven in total) were clearly written, easy to follow and looked to be appropriate for the documented wounds. Where people had more than one wound, there were care plans for each wound. Nursing staff told us they had wound care training within the last few months and all felt very competent to identify and care for people with wounds. We were told when people developed wounds staff had strong links with the Community Matron for advice and support. Communication within the nursing home was good. We spoke with a visiting health care professional who confirmed that there had been improvements in clinical care generally, particularly wound care.

Most care records of people we reviewed evidenced good examples that people were assessed for any risks regarding their health care needs. For example, risk assessments had been carried out to assess people's risk of developing a pressure sore and risk assessments for the use of bedrails to help ensure people were safe. Dietary needs and nutritional requirements had also been recorded and assessed routinely using an appropriate assessment tool (Malnutrition Universal Screening Tool – MUST).Weight charts were seen and had been completed on a monthly basis.

We found that four of the MUST assessments reviewed contained inconsistencies in their calculations. The clinical services manager for the home confirmed that this was a known issue and was being addressed by the service. One person had lost a considerable amount of weight and had been referred to a dietician

within the last few weeks however on reviewing the MUST score has this been calculated correct action could have been taken two months earlier. The registered manager showed us other monitoring tools used to identify risk of weight loss at organisational level and how people's weight loss was managed effectively in most circumstances. We saw that any person who had lost more than two kilograms of body weight over the preceding month were reported to the registered manager who followed through by ensuring a review had taken place.

We asked about the provision of enough staff at the home to ensure delivery of safe care. We visited all units and found staffing numbers stable at the time of our visit. Interviews with relatives, visitors and staff on the units all confirmed that staffing was settled. Staff morale was found to be positive with staff reporting there was always enough staff to carry out care.

We spoke with people living in the home and relatives / visitors who told us, "Yes, I feel safe, I am going to stay here now." "It's very nice here, I feel safe, and I have a lot of friends here." "I feel safe wherever I go here, thanks". "I like living here; I am not worried about anything". ''The staffing levels are much better; I have no worries now.'' A relative said, "Yes it's safe, I wouldn't dream of putting (name) anywhere not safe". There was universal agreement that people felt confidence in the ability of the staff to support them.

Observations of routine care on all units evidenced a good ratio of staff. Staffing rotas showed this had been consistent over a number of months. We observed there were enough staff to carry out care in a timely manner. We saw staff were attentive to people's daily personal care needs. For example, we observed people living with dementia or had a learning disability were attended to quickly when they became agitated or wanted assistance and also people on the nursing units received routine care in a timely manner. When we looked at the duty rotas for each unit we saw that the provider's designated numbers of staff were being met.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at three staff files and asked the manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were 'fit' to work with vulnerable people.

Staff we spoke with had a good understanding of the importance of maintaining people's safety and reporting any concerns, including alleged abuse, to the manager of the home. One staff said, "We do get training and if I had any concerns I would go straight to the managers. I'd have confidence they would act.''

There had been eight safeguarding incidents that had occurred since the last inspection. These were incidents or examples of care were people could be at risk of abuse and neglect and required investigation. Four of these were incidents involving medication errors. These had been picked up by the home's own audits [checks] and notified appropriately. Three of the incidents were around serious injuries sustained by people who were receiving care at the home and one was following unexplained bruising for a person.

The home had assisted the local authority safeguarding team and agreed protocols had been followed in terms of investigating which helped to ensure any lessons could been learnt and effective action taken. This approach helped ensure people were kept safe and their rights upheld. We saw that the local contact numbers for the Local Authority's safeguarding team were available along with the home's safeguarding policy.

We checked some specific maintenance and safety records. We looked at fire safety maintenance records and these were up to date. Personal evacuation plans (PEEP's) were available for the people living in the

home. These were displayed at the entry to each unit and were checked on a regular basis and maintained for easy reference. We carried out a spot check of a number of safety certificates for gas safety, electrical safety, infection control, and safety checks for the temperature of the hot water and equipment such as, bed rails, wheelchairs, hoists and other equipment. These were up to date and evidenced good monitoring of environmental safety in the home.

During the inspection the fire alarm was activated. The alarm sound was limited to the unit and the main office. Staff responded correctly and assembled at the evacuation point. The fire alarm was appropriately actioned.

All units were secure and access could only be gained by inputting the correct code into the key pad at the entrance, the code to exit the unit being different. There was also a signing in book for visitors to the unit and it was observed that relatives signed in and also knew the code to access the unit. The code was changed regularly.

Housekeepers were present on the units and the majority of areas seen were clean. Visitors and people we spoke with on the inspection told us they had no concerns about the cleanliness of the home. The management team completed infection control audits, as part of monitoring safe standards in the control of infection. Each of the units had an infection control lead and we spoke with one of the infection control leads. We were shown the local audits / checks carried out on a routine basis and were told how findings were fed upwards to managers. The infection control lead told us about meetings held with Liverpool Community Health (LCH - infection control) in order to learn and share best practice. These meeting had become less regular however and we spoke with the registered manager about the reasons for this. They said they would try and encourage meetings to be held regularly but at perhaps less frequency to ensure better attendance.

During our visit we did notice some standards of hygiene were not wholly maintained and these were discussed with the registered manager so they could be audited in the future. For example, the floor was not mopped after breakfast on one unit and it remained not clean for the lunch time service.

Requires Improvement

Is the service effective?

Our findings

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the last inspection in February 2016 we had made a recommendation around the use of mental capacity assessments as these had been generalised assessments rather than evidencing specific decisions and follow the guidance in the Mental Capacity Act Code of Practice.

We saw examples where people had been supported to make key decisions regarding their care. Where people may have lacked capacity to make decisions we saw that decisions had been made in their 'best interest'. We saw a good example where a person was being supported to maintain their independence and encouraged to make decisions for themselves even though they had some mental capacity issues. The person was being supported to go out into the community on a daily basis. They had signs of cognitive impairment but wanted to be supported to live as normal a life as possible. We saw that there had been effective liaison with the community mental health team (CMHT) regarding assessment of the person's capacity to make this decision. The assessment was a 'best interest decision' although the person was stated to have capacity at the time of assessment by the CMHT.

In another example a person on the learning disability unit had supporting documentation in their care notes around a living will and fact that the nearest relative had a lasting Power of Attorney (LPA) to show they could make decisions for the person.

We still found hesitancy around fully understanding the use of the 'two stage mental capacity assessment' and when this should be used. Admission assessments for people we reviewed contained a section called 'capacity decisions over care planning process' and this covered sections on all the activities of daily living in the care plan. This was completed for the people we reviewed but again, was confusing as the 'evidence' section, on most we saw, did not contain any evidence of the two stage mental capacity test having been carried out for these 'decisions'. In other, more specific examples, where a mental capacity assessment would have been evidence of good practice; for example the use of bedrails which can be interpreted as a restrictive practice. We did not find any evidence of consent or individual mental capacity test for this specific decision for people who were said to lack capacity by staff.

Some staff spoken with struggled with the concept of mental capacity and consent. They stated that they all had training but when we looked at their knowledge in more detail they struggled to explain some of the decision making processes. For example, one person had a mental capacity assessment carried out

regarding their ability to partake and understand the care planning process which clearly indicated they had capacity to do this. The 'consent to care documentation' was signed by the person. The section on the form to complete if the person did not have consent was also completed and signed by the relative. Consent for photography was signed by the relative and, in addition, staff had applied for a Deprivation of Liberty Authorisation (DoLS) even though the person had been assessed as having capacity to make decisions regarding their care planning. Staff spoken with could not explain the rational for this.

There was clear evidence that families were consulted with regarding LPA and what authority they had. However this was accepted verbally and there was no copies of the authority in place available in care notes to evidence this which would be in line with best practice.

The current documentation used did not reinforce staff to consider consent in line with the principles of the MCA as assessments were 'generic' rather than specific to individual key decisions. The current assessment form has a response box to say 'variable' when completing the two stage mental capacity assessment but this undermines the principle that the person either has or has not the mental capacity to make that particular decision at that time.

We looked at the guidance issued for staff by the provider. The guidance issued for staff and easily accessible on each unit talks about 'best interest decisions' but there was no reference to the use of the mental capacity assessment tool and how this should be used as part of the process for assessing people's mental capacity to make specific key decisions.

We discussed these findings with the registered manager who said they would take on board our comments and review staff's knowledge and understanding around this subject.

This is a breach of Regulation 11of the HSCA 2008 (Regulated Activities) Regulations 2014.
Need for consent.

We looked at 'do not attempt cardio pulmonary resuscitation' (DNACPR) for 19 people on three units. These were completed appropriately and decisions made in peoples best interests were supported by additional support plans and assessments.

People we spoke with at the inspection told us they felt staff had the knowledge and skills to support them with their care. At the last inspection in February 2016 we had raised some concerns around specific aspects of care which we found placed people at risk. For example, pain management, wound care and care for people on enteral feeding [feeding via a tube into a person's stomach]. Our findings indicated that a number of people were placed at risk as the nursing staff showed a lack of clinical knowledge and expertise in these areas of care to support people safely and effectively.

Following the inspection in February 2016 the provider sent us a series of action plans and updates telling us how they would ensure nursing staff would be supported to update their skills. The last update told us, 'all nursing staff have commenced and are in the process of creating their own individual development plans'. Also that all nurses had completed competency checks in at least eight clinical areas to help ensure safe practice.

We checked this out on our inspection and found improvements had been made and the breach of regulation was now met.

We looked at the training and support in place for nursing staff. We were able to review the training matrix

which showed training updates had been provided for nurse accountability, skin integrity, end of life care [in addition all nurses had been signed up recently to complete the 'six steps' end of life course], catheterisation, nutrition and falls prevention.

The provider, BUPA, have developed a revalidation support programme for nursing staff and this had started to be rolled out for staff. One nurse was able to show us their revalidation file which outlined personal learning and development to evidence update for continued nurse registration. The nurse told us, "There's been a big push on training. Any training I've requested has been organised. We have been updated and our competencies checked for infection control, safeguarding and issues around the Mental Capacity Act."

The registered manager was able to evidence that each staff member had a personal training programme which was being implemented.

We spoke with care staff who were able to tell us about how new staff were inducted and updated so they could reinforce and develop their knowledge base. The induction programme was covered over an initial four to five day programme covering subjects such as; role of the care worker, equality and diversity, dementia awareness, medicines and health and safety issues. New staff worked with more experienced staff as they became familiar with the service and got to know the people they supported. We saw staff had access to a training programme which included training in areas such as, moving and handling, first aid at work, health and safety, medication, safeguarding, infection control, food safety and fire awareness.

We were provided with more training details and this included more specific training for staff in areas such as, falls prevention, nutrition, 'behaviours that we find challenging', pressure ulcers, person first dementia and mental capacity. The training audit dated 4 August 2016 showed that 65.4% of staff had completed the 'person first' dementia training and 100% had attend a basic awareness course in dementia. The average compliance for St Nicholas Nursing Home in staff training was higher than the average for other BUPA services.

Care staff were also encouraged to gain qualifications in care such as, QCF (Qualifications and Certificates Framework). 55% of staff had completed their NVQ / Diploma in level 2, 3 or 4 and a further 10% of the staff were actively working through the courses. There were a number of staff who had requested their NVQ training as part of their training and development plan and the registered manager told us these would be facilitated to sign up within the next month.

Staff told us they had regular support sessions with their line managers such as supervision sessions and staff meetings. One staff commented, "The managers are excellent. Any training or support you need is sorted out. I've not long started here and I've been made very welcome by all staff." All staff spoken with echoed this.
We looked in detail at the care received by some of the people living at St Nicholas Nursing Home. One person, who had a learning disability, displayed some anti-social and challenging behaviour that staff had assessed well and developed a positive ongoing plan of care. We saw there had been effective liaison with supporting social and health care professionals as part of the ongoing review process. The relative of the person commented, " Staff are very consistent. They listen and are willing to work with us to support [person]."

We looked at the care of people living with dementia. We saw all had received input from a range of social and health care professionals who had linked in effectively with the home. Professional support had been documented by the Community Mental Health Team [CMHT] in some of the care records seen. On one day

of the inspection we saw a GP visit a person for review of a medical condition. Relatives commented that staff were quick to liaise with health professionals once they identified an issue needing attention.

The home benefited from regular [daily] input from the community matron who was available to provide support when asked. The community matron said that staff supported people well and communication had improved with external professionals over the past six months. They identified end of life care as an example of good care where staff liaised well with external professionals and families to support people.
We were also told about the 'Tel-med' (Telemedicine pilot system) whereby staff in the home could access local GP surgeries for support regarding people in the home.
We discussed with staff and the people living at the home how meals were organised. We recorded mixed opinions but the majority of people told us the meals were good and well presented.

Both the breakfast and lunch time service we observed was relaxed and unhurried (but the loud music from the lounge area was an intrusion). We were informed by staff that people were given the opportunity to choose their meals the day before. On the day of the inspection lunch was either a hot choice of Bubble & Squeak or soup and sandwiches or a choice from the light bite menu which comprised of dishes such as jacket potatoes, salads, omelettes, for example. The dessert was fresh fruit salad, when asked staff said yogurts or whole fruits were also available. There was no vegetarian option on the day of the inspection and when asked we were directed to the light bite menu. The main meal of the day was served in the evening and we were told that there was a choice of two cooked meals and again sandwiches or the light bite menu. Staff told us hot puddings with custard were usually served in the evening. There were no menus available on notice boards or in the dining room. The light bite menu on Gladstone unit care unit was not dementia friendly with the print being quite small and coloured pale blue on a white background (this was commented on at our last inspection but had not changed). We discussed ways this could be improved so that people could be more aware of the menu.

People we spoke with clearly felt positive about the food served. Their comments included; "I love the food here", "I enjoyed what I had for breakfast", "The breakfast was good", "I always enjoy my breakfast, the usual is cornflakes and a drink of tea" and "It's always a surprise, its usually nice, they look after you fine here with the food."

All of the nursing units had a designated 'hostess' who provided extra support with meals. Nobody was rushed. We saw staff asking people if they wanted an alternative to what was being offered. We also saw staff canvassing people for their choice of future meals.

We saw how the environment had been designed and adapted to meet people's needs. This varied on each unit. Staff on the learning disability unit, Brocklebank, were able to show us how innovations such as the sensory room and the specially designed garden helped people with their daily quality of life.

On one of the dementia care units we made some observations of good attention to design but saw that this could be further developed. The corridors had a selection of tactile murals on the walls and framed prints of old Liverpool and movie stars from the past. There was a notice board to promote the activities of the week but it had not been completed for the week of the inspection. The doors to the people's rooms were painted deep blue, red or green and had large brass door numbers on them along with very small name plates which were not positioned at eye level. Due to the small size of font they were quite difficult to read. There were memory boxes on the wall next to each respective door but the majority of these were empty. The staff told us they were being updated.

There are no pictures of the respective residents on their doors and it was unclear how some people would

recognise their own room with the doors closed. When asked, a staff member told us there were no pictures on the doors as they could upset people as they would not necessarily recognise themselves but they knew their respective room number. However, when we asked people appeared unsure of this information. While whilst people living with dementia may not recognise pictures of themselves as they are today they may well recognise photographs taken some years ago, perhaps of their wedding day or other special occasion. It was noted that the rooms visited had a selection of family photographs including some of the person concerned and one had a family tree on their wall.

We saw an audit carried out by the admiral nurse [nurse specialising in dementia care] employed by the provider. The audits are carried out periodically and help identify areas for further improvement. We were told that Gladstone unit had a higher score than other BUPA homes for providing a positive lifestyle for people with dementia.

Good

Is the service caring?

Our findings

Staff were observed to listen and speak to people appropriately. Staff were seen to be very caring when talking to and assisting people. One staff member was overheard to say to a person in a very pleasant tone, "Here's your walking stick, take your time there's no rush. Let's walk round to the dining room slowly." Comments made by people included: "The carers work hard, we praise them, they are very good", "The staff are alright with me", "I never complain, I just get on with it, generally speaking they (staff) are very good", "The staff will do what you ask them to do", "I'm looked after properly." One relative said, "They care for me as well; they (staff) know when I visit and if I don't arrive they will ring me to see if I am alright."

The observations we made on all units were generally very positive in evidencing good and appropriate personal care and staff were observed in most cases to provide appropriate and timely care. For example, we saw many instances of staff assisting people to the toilet and they did so in a very supportive and kindly way walking at the pace of the person and giving reassurance. There were some omissions and we fed these observations back to unit managers and the registered manager for on-going consideration. For example, we saw some bedroom door left open exposing the person to passers-by and infringing their privacy; we were not sure of the consent issues involved. There was no information in care records as to the rational for propping open doors even with the correct equipment. Also one person was escorted to the toilet having already been incontinent in a way that possibly compromised their dignity.

People spoken with and their relatives felt there had been on-going improvements to the consistency of care staff attention to personal care and also the way staff and managers listened to any concerns and acted on them. These improvements had been noted since the registered manager had started a year ago.

We spent periods of time throughout the day observing and listening to staff to see how they interacted with the people they supported. This interaction was positive and people appeared at ease and comfortable in the presence of the staff. When the staff supported people with daily tasks and activities this was carried out in a patient and caring manner so that people were assisted at their own pace. Staff explained to people what they were going to do, sought their permission before assisting and ensured people's comfort before leaving them. We saw many examples of this including staff support over lunch and assistance with aspects of personal care. This support was offered at the appropriate time. We saw staff offering people choices such as was they would like to sit in the lounge, what they would like to eat and drink at lunch and encouragement to take part in social activities.

We discussed with staff people's care needs. Staff showed a good understanding and knowledge of how people wished to be supported and the level of care they needed to maintain their health and wellbeing. A staff member said, "The main thing is we have enough staff so were not rushed. We can spend some time with [people]."

Brocklebank unit supports people with a learning disability. Staff told us about understanding people as individuals and knowing them well which helps to give the right care. For example, staff told us about the strategies in place to support a person who had a behaviour that may challenge. Staff were very aware of

triggers or factors that may cause distress or anxiety and how to support them during these episodes.

We saw that advocates such as, family members, were involved (where appropriate) with the care reviews, as part of evidencing their inclusion in the plan of care. We saw friends and relatives visiting during the inspection. Visitors were warmly welcomed by the staff and it was evident staff knew families well. A relative told us they could visit any time and were always able to speak with the staff.

For people who had no family or friends to represent them, contact details for a local advocacy service were available. People could access this service if they wished to do so with or without staff support. Three of the people living at the home had representation form an Independent Mental Capacity Advocate [IMCA] and two had support from two different local advocacy services in Sefton. We could not see advocacy service advertised on any of the units. We were told this would be arranged. All units had the contact numbers of local advocacy services.

We did not review anybody on end of life care. We did however get positive feedback from a health care professional who works with the home on a regular [daily] basis. We were told that this aspect of care was well managed and staff had showed consistency and a good knowledge base for carrying out care. A programme known as 'Six Steps' was being rolled out to staff to help ensure people's care was provided in line with their and their loved one's wishes. This programme included staff training in 'end of life' care.

Requires Improvement

Is the service responsive?

Our findings

We looked at how people were involved with their care planning and saw some evidence that people's plan of care had been discussed with them and/or their relative to evidence their inclusion. A relative told us about their involvement with their family member's care including regular care reviews. We saw a plan of care on Canada Unit where the family had been involved in key decisions regarding the care of a person on the unit and the person's changing care needs had been discussed. We also reviewed a person who presented as wanting to go out regularly and this was being managed with respect to the person's individual preferences and inclusion.

One nurse explained that one of their people was identified as needing one hourly turns [repositioning]. We were told the team discussed that the person was being disturbed every hour and they thought this excessive for a frail elderly person. They trialled an increase to the interventions to turn the person every 90 minutes though within a short time the person's skin was showing signs of becoming red. The staff reverted to their 60 minute turn time for this person. This is evidence of concern for a person's wellbeing and personalising the care plans to meet the person's individual care needs.

On the dementia care unit [nursing] people's support plans were signed by their relatives where appropriate and, where possible the people, themselves had signed their own care plans. On Brocklebank unit we spoke with a relative who told us, "I've been fully involved at all stages of care and staff have been excellent when there is a need for any referrals [to the health team] and have kept be fully involved."

All of the care files we looked at varied from unit to unit in evidencing person centred ways of working. All care files had a 'my day, my life portrait' which contained relevant information about the person, including their likes and dislikes and any medical conditions. On Brocklebank and Gladstone and Huskinson units care records contained information about individual preferences. Likewise on Canada unit we found good examples where care plans had been devised with reference to people's individuality. Other records were not as well developed and there was limited information regarding people's personal preferences and choices. Care records on Langton read similarly with the same actions ascribed across a wide variety of different people and conditions. An example, was with regards to pain for three people whose care plan told us to 'watch for facial expressions and body language' when assessing pain rather than specify each individuals presentation. The same actions were repeated for one person who experienced pain and constipation. When we spoke with staff they were able to describe and understand how each person presented as individuals.

We would recommend that existing good practice regarding the individualisation of care plans and records is extended to all people's care.

We saw that care plans were regularly reviewed by staff. This standard was not wholly consistent however. One care plan [for falls] was missing / not been updated following transfer to another unit.

We looked at how social activities were organised and asked the staff to tell us about how people liked to

spend their day. The staff informed us that people enjoyed the social programme and were able to take part in a variety of social activities on all the units. An activities coordinator was present on most of the units during our inspection. When we saw people taking part in activities they appeared to be enjoyed for the most part and the activities coordinators displayed good skills in encouraging people to participate. Organised activities included arts and crafts, board games, cake baking, singing, music, movie afternoons, gentlemen's and ladies club and use of a hydrotherapy pool and snoezelen; the latter on Brockleback unit. This is a room which provides a multisensory environment to provide therapy for people with autism and other developmental disabilities or dementia. Another example were the 'Chat boxes' on a dementia unit which included photographs and items of importance for people to encourage general conversation and reminiscence.

On Brocklebank unit and Gladstone unit activities were generally well developed. On Brocklebank we were told about holidays that are planned for people. One visitor said, "The social activities are good, there is always something going on." We made some observations that are included below that both highlighted the positive aspects of input currently as well as providing some indicators for future developments around more individualised activities.

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Gladstone Unit had its own activities co-ordinator who began work on the day of the inspection at 10.00am, before arriving on the unit they attended a meeting with the other co-ordinators and the activities lead to discuss the activities for the day. The day by day activities notice board for Gladstone Unit was not completed therefore people and their relatives did not know what activities had been planned for the day. On arrival the activities co-ordinator began allocating games and colouring activities to various people sat in the lounge area. At 11.00am we observed two people playing dominoes with the help of the co-ordinator and one person was given colouring to complete. Another person was given knitting to do, there were approximately six stitches on the needles which would produce a very narrow strip of knitting; the person concerned nor the co-ordinator had any idea of what it would be used for. This person was a very competent knitter and could have perhaps knitted squares to be sewn together to form blankets for the comfort dolls available on the unit or with some other focus in mind. Other people were seen to be sleeping.

The activities co-ordinator selected a DVD of a Daniel O'Donnell performance and proceeded to play it. One person left saying they did not like this type of music another person said they liked to listen to piano music, although another person clearly enjoyed it. The music was left for a prolonged period and was, at times invasive to other people.

The minutes from the last relatives meeting said, '[relative] would like to see more walks round the grounds. Would appear at times that focus is on people who can participate and not those that can't'.

One person who was reading a book in the dining room said, "There's nothing I can do apart from reading my book". When asked what they might like to do they said, "I like going out but I can't walk far." When we suggested they might go out in a wheelchair, they commented, "I'd like that, if it got me out it would be OK." One relative told us their loved one did not take part in the activities and preferred to sit in their room during the afternoon.

We spoke with a visiting nurse specialising in dementia [Admiral Nurse] who told us activities as yet are not wholly meaningful to individuals but are an improvement over what was previously in place and are continuing to develop.

The home had a complaints procedure in place. The registered manager showed us a log of complaints

since the last inspection. There had been four concerns / complaints since February 2016. These included three issues around care and an issue relating to previous admission of a person in 2013. All had, or were, being responded to and two had now been closed. These included an 'action plan' for any follow up and lessons learnt.

Residents' and relatives' meetings took place to enable people to raise their concerns regarding these issues and any further issues or comments regarding the service. We saw minutes of meetings displayed on units. There had been discussion and information shared regarding staffing and relatives involvement with relative surveys and laundry issues.

Requires Improvement

Is the service well-led?

Our findings

We found established and well developed systems of management in many areas. Being a large national provider BUPA ensured there were systems in place to monitor the running of the home. The home had an on-going service improvement programme (SIP) which has been regularly updated and sent to us (Care Quality Commission). There had been improvements in wound care, staff support and training and development of a more person centred approach to some of the care.

The home has been in 'special measures' since the last inspection following the overall rating of inadequate. This means the home needed to improve standards on this inspection. BUPA approach to this was to support the registered manager by the utilisation of a 'Service Recovery Team'. On a practical level these meant visits by members of the team and a monthly home review by the regional manager. On the inspection we did not see any members of the team apart from the regional manager who we provided some feedback along with the registered manager.

As part of our feedback to the registered manager and regional manager, we discussed the on-going development of the service with respect to our concerns. We spoke with the regional manager who told us that the provider are currently undergoing a 'redesign project' which will look at the way the providers larger services (such as St Nicholas Nursing Home) are configured and managed. This is to evaluate if changes to overall management structure, including possible registration, could help develop the service and promote positive outcomes. We noted we had this discussion at the previous inspection in February 2016.

We saw the 'Monthly Home Review' for August 2016 carried out by the regional manager. This had identified some areas of improvement such as 'personalised one to one activities to be planned' but had not picked up on the issues we had identified for improvement.

Despite improvements in many areas of management of the home and the continued development of a more positive overall culture, we found persistent on-going concerns around some clinical issues. These had not been effectively monitored but systems in place had not supported improvements. For example, the continued breaches concerning medication management and other areas we had identified on inspection such as; management of pain; the assessment of care not always ensuring the welfare and safety of people; changing care needs not been assessed or reflected in the risk assessments made and subsequent care planning in some instances; issues around first aid procedure and the inconsistency of knowledge and approach regarding the Mental Capacity Act 2005.

We saw that an underlying component to some of the continued failings was the accessibility and user friendliness of the care records and documentation in use. We found care records extremely bulky and difficult to negotiate. Staff felt this also and told us it took inordinate lengths of time to fill out and maintain effectively. We saw on occasions that some changes had not been recorded in a timely manner. Other changes recorded were repeated over a number of areas of care causing information to be repeated adding to the bulk of the records. Simple information such as the last time a person had had a bath or shower could not be located in one instance.

All care staff spoken with did not access care plans. They said that they were "Way too long", "Impossible to find what you need" and "of no use." A visiting professional said "Staff really try their best and I do think service users are generally safe. However the records are so [difficult to negotiate] it's almost impossible for them to monitor."

Care records were audited but the audits had failed to recognise omissions we identified and the difficulties staff had both writing and accessing them. If staff find the care records difficult to access it is likely that service users and their relatives will also find their inclusion in this process difficult. We realised that the home had a review of care documentation a year ago and improvements had been made at that time.

This is a breach of Regulation 17(1) (b) of the HSCA 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager in post. We spent time talking to the registered manager [RM] and asked them to tell how to define the culture of the home and the main aims and objectives. Since being appointed as registered manager, there was feeling that standards in the home had improved and were more consistent. Over the past year there had been improvements in staffing [both consistency of staff numbers and staff support] and moral had improved significantly. We found a much more positive culture in the home than on previous inspections and this had continued since the last inspection.

Staff spoken with told us that all levels of management were more consistent in their approach and were more 'visible' around the home. Overall we received positive feedback about the management of the service. Staff told us the registered manager was very approachable and always available. Staff said the manager was open to suggestions and new ideas to help improve the service. Staff commented, "If it wasn't for [RM] I would have left some time ago. The improvements have been very good." A nurse said, "She's the best manager I've worked for. Both managers [clinical service manager as well] have been very supportive." A health care professional commented, "Since [RM] has taken over there have been a lot of improvements and they are continuing." A relative [also a social care professional] commented, "The [RM] is very good and very proactive at all levels. There is quality at the core of expectation."

The registered manager showed us the homes Statement of Purpose [SOP]. This was clear around the culture and values of the home. These included, 'involvement of service users' at all levels and this had been evidenced on the inspection as improving over the past year. The 'quality model' highlighted in the document included the 'resident' at the centre. There was copy of this document in the main reception area [although not conspicuous on the units].

Staff we spoke with were all very positive and 'on board' regarding the future direction of the home. They told us they were aware of the whistleblowing policy and would feel confident to use it; this has been evidenced in the past. This also helped to promote an open culture in the home. The Commission had not received any whistle-blower concerns since the last inspection.

We reviewed some of the quality assurance systems in place to monitor performance and to drive continuous improvement. The registered manager was able to evidence a series of quality assurance processes and audits carried out internally and externally from visiting senior members within the organisation. The systems, processes and audits had been developed to capture as full picture of the home as possible. Staff had a good knowledge of the current auditing systems and how these fed into the overall analysis of how the home was operating.

Findings from the audits and clinical risk reviews were discussed at clinical risk meetings with the heads of each unit; we saw any required actions were then completed. The registered manager discussed a key

management tool used to monitor the service. This was the 'Quality Metrics' report reflected in the companies 'Enhanced Quality Model' which had four key themes- 'quality of care, quality of life, quality of leadership and management and quality of the environment'. We discussed the Quality Metrics and the key indicators within this. These covered pressure ulcers (showing an increased in in-house incidents since October 2015), Nutrition (including people weight loss), Medication errors, safeguarding referrals, Deprivation of Liberty referrals, infection rates, care plan auditing, accidents and incidents (current low rate for these) and quality assurance feedback from people living at the home and their relatives.

The registered manager continued the use of a clinical indicator board in their office. This provided an anonymised over view of people's clinical care and dependencies based on the audits and staff's professional judgement. The registered manager and clinical services manager told us this was a valuable tool which provided an accurate overview of people's current health and wellbeing and was a valuable aid to ensuring people received safe, effective care as continued monitoring was made easier.

Another improvement was the way in which the service collects the views of people using the service and their relatives. In December 2015 people who lived at the service were given the opportunity to complete satisfaction surveys in the home. This was again followed up in May 2106; the latest survey. We saw the results of this were 18 people had returned surveys. The overall feedback was positive. Where areas for improvement had been identified these were highlighted on a letter to people and their relatives. For example under 'Wellbeing & Activities: The feedback gained was that at times, 'activities did not suit everyone therefore there may be times when residents are left out and that they do not access fresh air as readily as they should. We introduced an individual activity programme sometimes ago based on feedback from one of our relatives meetings, we are in the process of revisiting these and it will form part of our audit progress, to review that we are supporting each of our residents to achieve their choice of activity'.

Resident/relative meetings were taking place on the units and minutes seen showed a range of topics discussed including how the home was now operating.

Through their day to day management the registered manager and clinical services manager (CSM) undertook a morning 'walk round' on the units to meet with the staff, visiting health professionals and people living at the home. This we observed during our inspection and confirmed through staff discussions. The registered manager told us the visual checks were an important part of monitoring standards and improving the service provision. Following our feedback the manager told us that a new (CSM) would be appointed to improve the clinical interface on the general nursing units.

The manager had notified CQC (Care Quality Commission) of events and incidents that occurred in the home in accordance with our statutory notification requirements.

From April 2015 it is a legal requirement for all services who have been awarded a rating to display this. The rating from the last inspection for St Nicholas Nursing Home was displayed for people to know how the home was performing.